

Facility Name & ID Number MAR KA NURSING HOME# 0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,816</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,267</u>	<u>7,576</u>	<u>2,951</u>	<u>21,794</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,267</u>	<u>7,576</u>	<u>2,951</u>	<u>21,794</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.35%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/ 23 /86

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/23/86 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 76 and days of care provided 2,001Medicare Intermediary NGS (ADMINISTAR FEDERAL)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 9/30/08 Fiscal Year: 9/30/08

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,717	15,315	3,508	178,540		178,540		178,540		1
2	Food Purchase		99,574		99,574		99,574	(335)	99,239		2
3	Housekeeping	121,905	10,058		131,963		131,963	153	132,116		3
4	Laundry	39,424	16,680		56,104		56,104		56,104		4
5	Heat and Other Utilities			89,164	89,164		89,164		89,164		5
6	Maintenance	30,794	23,168	28,825	82,787		82,787	200	82,987		6
7	Other (specify):*										7
8	TOTAL General Services	351,840	164,795	121,497	638,132		638,132	18	638,150		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	834,434	142,549	3,900	980,883		980,883	22,820	1,003,703		10
10a	Therapy		165	159,320	159,485		159,485		159,485		10a
11	Activities	48,255	6,382	2,665	57,302		57,302		57,302		11
12	Social Services	35,052	153	1,894	37,099		37,099		37,099		12
13	CNA Training										13
14	Program Transportation			703	703		703		703		14
15	Other (specify):*			52	52		52		52		15
16	TOTAL Health Care and Programs	917,741	149,249	174,534	1,241,524		1,241,524	22,820	1,264,344		16
	C. General Administration										
17	Administrative	57,993			57,993		57,993	21,512	79,505		17
18	Directors Fees										18
19	Professional Services			102,068	102,068		102,068	(86,408)	15,660		19
20	Dues, Fees, Subscriptions & Promotions			49,051	49,051		49,051	(7,463)	41,588		20
21	Clerical & General Office Expenses	23,942	10,450	19,220	53,612		53,612	40,830	94,442		21
22	Employee Benefits & Payroll Taxes			237,941	237,941		237,941	12,790	250,731		22
23	Inservice Training & Education			3,401	3,401		3,401		3,401		23
24	Travel and Seminar			6,232	6,232		6,232	5,102	11,334		24
25	Other Admin. Staff Transportation							324	324		25
26	Insurance-Prop.Liab.Malpractice			38,596	38,596		38,596	40	38,636		26
27	Other (specify):*										27
28	TOTAL General Administration	81,935	10,450	456,509	548,894		548,894	(13,273)	535,621		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,351,516	324,494	752,540	2,428,550		2,428,550	9,565	2,438,115		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAR KA NURSING HOME #0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			42,046	42,046	42,046	42,222	84,268			30
31	Amortization of Pre-Op. & Org.						181	181			31
32	Interest						39,114	39,114			32
33	Real Estate Taxes			37,174	37,174	37,174		37,174			33
34	Rent-Facility & Grounds			250,800	250,800	250,800	(242,634)	8,166			34
35	Rent-Equipment & Vehicles			941	941	941	3,724	4,665			35
36	Other (specify):*										36
37	TOTAL Ownership			330,961	330,961	330,961	(157,393)	173,568			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			41,724	41,724	41,724		41,724			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			41,724	41,724	41,724		41,724			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,351,516	324,494	1,125,225	2,801,235	2,801,235	(147,828)	2,653,407			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending: 09/30/08

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,095)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(335)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,790)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,997)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(297)	20		28
29	Other-Attach Schedule	(1,249)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,763)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(136,065)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (136,065)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,828)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		6,061	10.2	42
43	Prescription Drugs	X		79,827	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 85,888		47

BHF USE ONLY						
48		49		50		51
						52

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/01/07

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	\$ (1,230)	20	1
2	MISCELLANEOUS INCOME	(19)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,249)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/07

Ending:

09/30/08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(335)	0	0	0	0	0	0	0	0	0	0	(335)	2
3	Housekeeping	0	0	153	0	0	0	0	0	0	0	0	153	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	200	0	0	0	0	0	0	0	0	200	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(335)	0	353	0	18	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,820	0	0	0	0	0	0	0	0	0	22,820	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	22,820	0	22,820	16								
	C. General Administration													
17	Administrative	0	21,512	0	0	0	0	0	0	0	0	0	21,512	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(86,408)	0	0	0	0	0	0	0	0	0	(86,408)	19
20	Fees, Subscriptions & Promotions	(7,524)	0	61	0	0	0	0	0	0	0	0	(7,463)	20
21	Clerical & General Office Expenses	(2,809)	43,639	0	0	0	0	0	0	0	0	0	40,830	21
22	Employee Benefits & Payroll Taxes	0	12,790	0	0	0	0	0	0	0	0	0	12,790	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,102	0	0	0	0	0	0	0	0	0	5,102	24
25	Other Admin. Staff Transportation	0	0	324	0	0	0	0	0	0	0	0	324	25
26	Insurance-Prop.Liab.Malpractice	0	0	40	0	0	0	0	0	0	0	0	40	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,333)	(3,365)	425	0	(13,273)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,668)	19,455	778	0	9,565	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/07 Ending:

09/30/08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	42,222	0	0	0	0	0	0	0	0	0	42,222	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(1,095)	40,209	0	0	0	0	0	0	0	0	0	39,114	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(242,634)	0	0	0	0	0	0	0	0	0	(242,634)	34
35	Rent-Equipment & Vehicles	0	3,724	0	0	0	0	0	0	0	0	0	3,724	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,095)	(156,298)	0	0	0	0	0	0	0	0	0	(157,393)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(11,763)	(136,843)	778	0	(147,828)	45							

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/07

Ending:

09/30/08

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>JAMES J. GIARDINA</u>	<u>100</u>	<u>MONMOUTH NURSING HOME</u>	<u>MONMOUTH</u>	<u>COMMUNITY CARE CTRS, INC.</u>	<u>BALLWIN, MO</u>	<u>HOME OFFICE</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>W/C INS</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>LIAB INS</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>34 BUILDING RENT</u>	\$ <u>250,800</u>	<u>JAMES J GIARDINA</u>	<u>100.00%</u>	\$	\$ <u>(250,800)</u>	1
2	V	<u>32 INTEREST EXPENSE</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>40,209</u>	<u>40,209</u>	2
3	V	<u>30 DEPRECIATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>42,222</u>	<u>42,222</u>	3
4	V	<u>31 AMORTIZATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>181</u>	<u>181</u>	4
5	V	<u>19 HOME OFFICE</u>	<u>88,800</u>	<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>		<u>(88,800)</u>	5
6	V	<u>34 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>8,166</u>	<u>8,166</u>	6
7	V	<u>35 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>3,724</u>	<u>3,724</u>	7
8	V	<u>10 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>22,820</u>	<u>22,820</u>	8
9	V	<u>17 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>21,512</u>	<u>21,512</u>	9
10	V	<u>21 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>43,639</u>	<u>43,639</u>	10
11	V	<u>22 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>12,790</u>	<u>12,790</u>	11
12	V	<u>19 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>2,392</u>	<u>2,392</u>	12
13	V	<u>24 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>5,102</u>	<u>5,102</u>	13
14	Total		\$ <u>339,600</u>			\$ <u>202,757</u>	\$ * <u>(136,843)</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAR KA NURSING HOME# 0031740Report Period Beginning: 10/01/07Ending: 09/30/08

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	25	HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC.	COMMON	\$ 324	\$ 324	15
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	200	200	16
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	61	61	17
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	40	40	18
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	153	153	19
20	V	22	WORKERS COMP INS	72,909	RISA	25.00%	72,909		20
21	V	26	LIABILITY INS	34,200	RISA	25.00%	34,200		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 107,109			\$ 107,887	\$ * 778	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	2	4.00	SALARY	\$ 15,747	17.7	1
2	BETTY HUGHES	SECRETARY			NONE	1	2.00	SALARY	1,317	17.7	2
3	LORRAINE BOYET	SECRETARY			NONE	2	4.00	SALARY	1,664	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,728		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending: 09/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization COMMUNITY CARE CENTERS, INC.
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63021
 Phone Number (636-394-3000
 Fax Number (636-394-7713

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	WEST COUNTY CARE CENTER				\$	\$	5,576,345	\$ 282,290	1
2	ST GENEVIEVE CARE CTR						2,367,632	83,909	2
3	CCC OF LEMAY						2,479,484	96,051	3
4	SALEM CARE CENTER						1,746,988	63,666	4
5	MONMOUTH NH						2,126,548	81,939	5
6	MAR-KA NH						2,712,435	120,923	6
7	CCC OF SENECA						2,734,042	100,226	7
8	MT VERNON PLACE CARE						2,601,692	98,578	8
9	COUNTRY VIEW NH						2,220,110	88,721	9
10	MERAMEC NH						2,805,995	108,740	10
11	SEVILLE CARE CENTER						3,145,601	112,149	11
12	SALEM RES CARE						556,627	19,492	12
13	CARL JUNCTION RES CARE						612,517	21,449	13
14	MT VERNON RES CARE						462,316	16,190	14
15	SENECA HOME PLACE						447,852	15,684	15
16	HUDSON HOUSE						517,592	18,125	16
17	MAPLE GROVE LODGE						3,049,347	117,264	17
18	CCC OF AURORA						4,817,184	170,686	18
19	BARRY COMMUNITY CARE						2,824,348	99,903	19
20	LICKING RESIDENTIAL CTR						445,895	15,614	20
21	CCC OF GAINESVILLE						2,514,144	94,279	21
22	AL OF SILVER CREEK						654,275	22,912	22
23	CCC OF LICKING						2,483,065	97,672	23
24	COMMUNITY IN HOME						913,173	32,238	24
25	TOTALS				\$	\$		\$ 1,978,700	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAR KA NURSING HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0031740

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE (636) 394-3000 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-31.01-114-007</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ <u>37,338.04</u>	\$ <u>37,338.04</u>
2. _____	<u>BLK/RG-6W PT LOT 12C</u>	\$ _____	\$ _____
3. _____	<u>AS IN BK 2659-1974</u>	\$ _____	\$ _____
4. <u>10-31.0-113-009</u>	<u>LOT/SEC-18 BK 2659-1974</u>	\$ <u>195.78</u>	\$ <u>195.78</u>
5. <u>10-31.0-114-009</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ _____	\$ _____
6. _____	<u>BLK/RG-6W BK 2659-1974</u>	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>37,533.82</u>	\$ <u>37,533.82</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number MAR KA NURSING HOME

0031740 Report Period Beginning:

10/01/07 Ending:

09/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,425 B. General Construction Type: Exterior BRICK Frame STEEL REINFORCE Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>48,000</u>	<u>Dec-86</u>	<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	48,000		\$ 75,000	3

Facility Name & ID Number **MAR KA NURSING HOME**# **0031740**

Report Period Beginning:

10/01/07

Ending:

09/30/08**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986	1970	\$ 950,000	\$	22.5	\$ 42,222	\$ 42,222	\$ 890,018	4
5			1986		14,621		10			14,621	5
6											6
7											7
8											8
		Improvement Type**									
9		ROOF REPAIR		1989	4,686		10			4,686	9
10		PATIO AND RAMP		1991	3,252		12			3,252	10
11		PATIO ROOF		1991	2,890		10			2,890	11
12		FLAT ROOF		1991	14,000		10			14,000	12
13		ROOF (NORTH WING)		1992	10,000		10			10,000	13
14		ROOF REPAIR		1990	7,055		10			7,055	14
15		SIDING REPAIR		1990	4,276		10			4,276	15
16		SPRINKLER SYSTEM		1993	2,168		25			2,168	16
17		BULLOCK GARAGES		1993	7,176		15			7,176	17
18		5 TON REFRIGERATION UNIT		1995	3,814		10			3,814	18
19		ROOF REPAIR		1995	18,785		10			18,785	19
20		LANDSCAPING - PATIO		1995	3,342		10			3,342	20
21		ROOFING REPAIR		1997	12,732		10			12,732	21
22		AIR CONDITIONING		1997	3,760		10			3,760	22
23		PHONE SYSTEM		1998	3,780		10			3,780	23
24		ELECTRICAL WORK		1999	3,613		20			3,613	24
25		COUNTERTOPS		1999	2,127		20			2,127	25
26		LENNOX 7.5 ROOFTOP UNIT		2000	5,733		10			5,733	26
27		ROOF ON EAST ASH WING		2000	6,400		10			6,400	27
28		MECHANICAL ROOM IMPR		2001	23,797		15			23,797	28
29		FIRE DAMPERS IN DUCT WORK		2001	1,900		15			1,900	29
30		FIRE DAMPERS IN DUCT WORK		2001	3,059		15			3,059	30
31		EXTERIOR KITCHEN DOORS		2002	1,567		20			1,567	31
32		RE-PLATE DOORS		2002	9,398		10			9,398	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/07

Ending:

09/30/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SEWAGE MOTOR EJECTOR PU	2003	\$ 1,567	\$	Lease Life	\$	\$	\$ 1,567	37
38	2 REMINGTON 9000BTU A/C'S	2003	1,135		Lease Life			1,135	38
39	2 REMINGTON 9000BTU A/C'S	2003	1,135		Lease Life			1,135	39
40	1 REMINGTON 9000BTU A/C'S	2003	566		Lease Life			566	40
41	5TON ROOFTOP A/C UNIT	2003	5,471		Lease Life			5,471	41
42	KATOLIGHT GENERATOR (\$20,641 desk audit adj off)	2004							42
43	RE-PAVE PARKING LOT-GRAVEL	2004	5,470		Lease Life			5,470	43
44	CARPET FOR OFFICES	2005	1,036		Lease Life			1,036	44
45	UPGRADE WANDERGUARD SYST	2005	4,997		Lease Life			4,997	45
46	ROOF OAK HALL, KITCHEN	2005	27,333		Lease Life			27,333	46
47	RIGHT SIDEWALK-CONCRETE	2005	6,298		Lease Life			6,298	47
48	HEAT EXCHANGER & THERMOSTAT FOR FURNACE	2006	2,962		Lease Life	1,015	1,015	2,793	48
49	GUTTERING & DOWNSPOUTS	2006	8,000		Lease Life	3,556	3,556	7,407	49
50	81 GAL WATER HEATER	2007	4,030		Lease Life	2,198	2,198	3,664	50
51	ROOF 300 WING	2007	17,000		Lease Life	10,737	10,737	15,211	51
52	CHANDELIER	2007	2,075		Lease Life	1,556	1,556	1,816	52
53	BRICK SIGNS	2008	6,450		Lease Life	5,458	5,458	5,458	53
54	LANDSCAPING IMPROVEMENTS	2008	1,800		Lease Life	1,080	1,080	1,080	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,221,256	\$		\$ 67,822	\$ 67,822	\$ 1,156,386	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 184,172	\$ 16,181	\$ 16,181	\$		\$ 132,150	71
72	Current Year Purchases	2,666	265	265			265	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 186,838	\$ 16,446	\$ 16,446	\$		\$ 132,415	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	1,483,094	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	16,446	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	84,268	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	67,822	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,288,801	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending: 09/30/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 940

Description: STORAGE RENTAL

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/07 Ending: 09/30/08

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	1,000	\$ 66,537	\$	1,000	\$ 66,537	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		77	5,700		77	5,700	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,368	87,084		1,368	87,084	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	2,445	\$ 159,321	\$	2,445	\$ 159,321	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending:

09/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 29,072	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>24,754</u>)	420,179		3
4	Supply Inventory (priced at)	1,650		4
5	Short-Term Investments	3,874		5
6	Prepaid Insurance	23,776		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due To/From Rel Parties</u>	(661,704)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (183,153)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	265,937		15
16	Equipment, at Historical Cost	186,838		16
17	Accumulated Depreciation (book methods)	(393,463)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Employee Advances</u>	48		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 59,360	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (123,793)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 633,692	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,206		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,259		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,583		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to/From Related Parties</u>	73,721		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 846,261	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 846,261	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (970,054)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (123,793)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (898,234)	1
2	Restatements (describe):		2
3	Prior Period Adjustment-Bad Debt Expense	(20,000)	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (918,232)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(51,822)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (51,822)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (970,054)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending: 09/30/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,532,895	1
2	Discounts and Allowances for all Levels	(10,344,555)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,188,340	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	399,382	6
7	Oxygen	158,194	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 557,576	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,271	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,271	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,095	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,095	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RESIDENT SALES/MISC INC	131	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,749,413	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	638,132	31
32	Health Care	1,241,524	32
33	General Administration	548,894	33
B. Capital Expense			
34	Ownership	330,961	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	41,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,801,235	40
41	Income before Income Taxes (line 30 minus line 40)**	(51,822)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (51,822)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX DEPRECIATION DIFFERENCE

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/01/07

Ending:

09/30/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,072	2,080	\$ 51,406	\$ 24.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,939	2,050	43,301	21.12	3
4	Licensed Practical Nurses	17,738	18,737	317,099	16.92	4
5	CNAs & Orderlies	40,834	42,481	410,416	9.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,989	2,149	25,363	11.80	9
10	Activity Assistants	1,684	1,996	22,892	11.47	10
11	Social Service Workers	3,010	3,183	35,052	11.01	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,150	23,988	11.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,403	4,673	46,821	10.02	15
16	Dishwashers	10,161	10,428	88,908	8.53	16
17	Maintenance Workers	1,875	2,075	30,794	14.84	17
18	Housekeepers	11,402	12,419	121,905	9.82	18
19	Laundry	4,768	5,036	39,424	7.83	19
20	Administrator	2,032	2,080	57,993	27.88	20
21	Assistant Administrator					21
22	Other Administrative	1,791	1,887	23,942	12.69	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,393	1,437	12,212	8.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	109,056	114,861	\$ 1,351,516 *	\$ 11.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	108	\$ 3,508	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	52	2,674	10.3	37
38	Nurse Consultant		226	10.3	38
39	Pharmacist Consultant	40	1,000	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,175	11.3	44
45	Social Service Consultant	29	1,894	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	295	\$ 16,477		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number **MAR KA NURSING HOME**

0031740

Report Period Beginning: **10/01/07**

Ending: **09/30/08**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ALICE GREEN	ADMINISTRATOR		\$ 57,993	Workers' Compensation Insurance	\$ 72,909	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	33,075	
				FICA Taxes	138,698	Health Care Worker Background Check	964	
				Employee Health Insurance	23,989	(Indicate # of checks performed <u>96</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	4,514	
				OTHER EMPLOYEE BENEFITS	1,894	TAXES & LICENSES	4,204	
				401K CONTRIBUTIONS	451	ADVERTISING OTHER	6,294	
						NONALLOWABLE IHCA DUES	(1,230)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,993			HOME OFFICE ALLOCATION	61	
(List each licensed administrator separately.)						Less: Public Relations Expense	()	
				HOME OFFICE ALLOCATION	12,790	Non-allowable advertising	(5,997)	
						Yellow page advertising	(297)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 250,731	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 41,588	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
COMMUNITY CARE CENTERS	MGMT FEES		\$ 88,800			\$	Out-of-State Travel	\$
ELVIDGE KELLEY	LEGAL		1,703				In-State Travel	6,232
HUSCH & EPPENBERG	LEGAL		24					
SCHINDLER	LEGAL		66					
NET COLLECTIONS	LEGAL		(270)				Seminar Expense	
							HOME OFFICE ALLOCATION	5,102
BKD, LLP	ACCOUNTING		11,745				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 102,068	TOTAL		\$	TOTAL	\$ 11,334
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HCA \$4,195
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 3-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,544 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,724
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 16%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. TO BE SENT WHEN COMPLETED
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.